BEFORE THE APPEALS BOARD
FOR THE
KANSAS DIVISION OF WORKERS COMPENSATION

MARIA HERNANDEZ	)	
Claimant	)	
VS.	)	
	)	Docket No. 1,055,412
ARAMARK MANAGEMENT SERVICES	)	
Respondent	)	
AND	)	
	)	
INDEMNITY INSURANCE CO. OF NORTH AMERICA	)	
Insurance Carrier	)	

ORDER

Claimant requested review of the January 18, 2013, Award by Administrative Law Judge (ALJ) John D. Clark. The Board heard oral argument on May 24, 2013, in Wichita, Kansas.

APPEARANCES

Randy S. Stalcup, of Andover, Kansas, appeared for the claimant. Dallas L. Rakestraw, of Wichita, Kansas, appeared for respondent and its insurance carrier.

RECORD AND STIPULATIONS

The Board has considered the record and adopted the stipulations listed in the Award.

ISSUES

The ALJ adopted the opinion of the court-ordered independent medical examiner, Dr. Vito Carabetta, and awarded claimant an 18 percent impairment of function to the right upper extremity at the shoulder level. He also found claimant entitled to all her outstanding medical expenses, unauthorized medical up to the statutory limit, and future medical treatment to be considered upon proper application to the Director.

The claimant requests review of the nature and extent of her disability and whether the appropriate impairment rating for all of her alleged injured body parts was assigned. Claimant argues that she suffered a shoulder and neck injury and is entitled to a 95.5 percent permanent partial general (work) disability, based on the opinion of Dr. Zimmerman.

Respondent contends the Award should be affirmed in terms of the impairment being limited to the right shoulder. Respondent argues the impairment should be 6 percent to the upper extremity at the shoulder, based on the opinion of Dr. Prohaska. In the alternative, respondent contends the award should be no more than 12 percent based on an average of the ratings of Dr. Prohaska and Dr. Carabetta.

FINDINGS OF FACT

Claimant's job for respondent was in housekeeping. Her job duties included mopping, picking up trash, cleaning rooms, picking up linens and sweeping. Claimant testified that she had to push carts as part of this job. When asked when her problems with her right upper extremity or shoulder began, claimant testified that it was October 21, 2010, when she could no longer stand the pain and decided to seek medical treatment. Claimant went to Wichita Clinic, on her own, for several visits, coming under the care of several doctors. Claimant's initial complaints involved her hands and arms and right shoulder, with pain and cramping. She also complained of a cough and a sore throat. Claimant was diagnosed with right shoulder strain and bronchitis. Later examinations displayed shoulder and neck pain, with the right shoulder being the most painful. X-rays of the shoulders displayed degeneration in both the right and the left shoulders, with the right being the most severe. Claimant reported the right shoulder pain as being ten times worse than the left shoulder pain. Claimant had a positive Tinel sign in the right wrist but not the left. Phalen's test was negative bilaterally. X-rays of the neck were normal.

At respondent's request, claimant was examined by Mark S. Dobyns, M.D., of the Wichita Clinic on November 22, 2010. Dr. Dobyns diagnosed claimant with shoulder strain on the right side and recommended an MRI, which demonstrated a rotator cuff tear involving an almost complete tear of the supraspinatus tendon.

Claimant was sent to John P. Estivo, D.O., on December 16, 2010. Her complaints were limited to the right shoulder at that examination. Dr. Estivo noted the rotator cuff tear was about 90 percent, and recommended a referral to Daniel J. Prohaska, M.D., an orthopedic surgeon, for right shoulder treatment. Dr. Estivo's only other diagnoses included an anxiety disorder and generalized complaints to multiple areas of claimant's body, which would come and go. Claimant testified that she also had problems with her

left shoulder and neck and reported those complaints to every doctor and physical therapist she saw.[1]

The only other day claimant worked after October 21, 2010, was April 5, 2011. She testified that she stopped working because she couldn't stand the pain and her neck hurt. She did not report this to her physical therapist, but did report it to Dr. Prohaska. Claimant testified that on April 8, 2011, she received a letter from respondent telling her that they no longer had work for her. The letter indicated that her termination was due to her not calling in or showing up for work on April 6 and 7. Claimant contends that she did call in on April 7 and left a message with the receptionist. Claimant testified that after every visit with Dr. Prohaska she received a list of restrictions. On at least two occasions claimant provided the restrictions to respondent.

Claimant reported that she has problems from the top of her neck down into her shoulders and into her back. She described the pain as strong. Claimant testified that her neck problems are worse today than they were back in October 2010.

Claimant met with Dr. Prohaska, on January 6, 2011, with complaints of right shoulder pain and loss of motion. Claimant reported that she began to notice pain in her shoulder in June 2010 and believed it was due to the repetitive nature of her job duties. Her pain began to worsen in September 2010. Which is why she reported it on October 21, 2010. Claimant rated her pain at 9 out of 10, with aching, throbbing, burning and occasional sharp and stabbing pain in the lateral deltoid and posterior shoulder. She also complained of weakness, loss of motion, swelling, numbness and tingling beginning in the elbow and radiating to her fingers.

Dr. Prohaska reviewed claimant's diagnostic studies, finding a right shoulder partial thickness rotator cuff tear and impingement. Surgery was scheduled for January 24, 2011, and claimant was given restrictions of no lifting over 3 pounds, no overhead work, and no pushing or pulling over 3 pounds. Post surgery, Dr. Prohaska diagnosed a high-grade partial thickness tear of the supraspinatus tendon at the rotator cuff, impingement and a SLAP type 1 tear.

Claimant was seen by Dr. Prohaska on February 4, 2011, eleven days post right shoulder arthroscopic subacromial decompression and rotator cuff repair. Claimant reported being 70 percent better, but continued to have constant pain at a 7 or 8 out of 10 level, and stiffness. She was also having trouble sleeping. Claimant was instructed to continue with physical therapy and to use the sling that was provided.

Claimant was next seen on March 15, 2011, seven weeks post right shoulder arthroscopic subacromial decompression and rotator cuff repair. She reported being 40-50

[1] R.H. Trans. at 15-16.

percent better, but her pain level remained at 8 out of 10. Claimant reported that most of her pain was in the front of her shoulder. She continued to take pain medication and to attend physical therapy twice a week. She reported that during therapy she had popping in her shoulder that caused her pain. Claimant was instructed to continue with her pain medication and physical therapy. She was allowed to return to work with restrictions of no lifting over 1 to 2 pounds and no overhead work.

At the May 5, 2011, examination with Dr. Prohaska, claimant reported no improvement. Instead, her pain had increased to a 10 out of 10 throughout her shoulder, with the pain being described as sharp, stabbing, aching, throbbing and burning. Claimant reported that her shoulder pain radiated into her neck and down into her hand. She described physical therapy as a nightmare and she had, for the last week, been doing a home exercise program. She had complaints of continued weakness, stiffness, swelling, numbness and tingling. She continued to be unable to lift her arm out to the side without extreme pain.

Dr. Prohaska expressed concern that claimant had a frozen shoulder, with enough stiffness to require an arthroscopy with lysis of adhesions and possible manipulation under anesthesia with possible capsulotomy. He indicated that the chances of claimant improving without surgery were dim. Dr. Prohaska scheduled the procedure and recommended physical therapy afterwards. The procedure was performed on June 20, 2011, with a post surgery diagnosis of right shoulder status post rotator cuff repair with postoperative stiffness.

On June 28, 2011, claimant reported some improvement following the surgery, with improved range of motion. She continued to complain of sharp, stabbing, and constant pain while at physical therapy. Claimant was prescribed pain medication and allowed to return to modified duty with restrictions, including no lifting over 5 pounds with the right shoulder. She was also instructed to continue with physical therapy.

Claimant was not seen again by Dr. Prohaska until August 9, 2011. She reported being 30 percent better, but continued to have throbbing, burning pain in her shoulder and complained of extreme headaches, dizziness and nausea, which she thought were being caused by her blood pressure. Dr. Prohaska felt that claimant's shoulder was making progress and recommended that she meet with her primary care physician regarding her blood pressure. He recommended monitoring of her blood pressure and prescribed more medication and recommended physical therapy. He imposed restrictions of no overhead work and no lifting with the right arm.

Claimant was seen for follow-up by Dr. Prohaska on September 20, 2011, at which time she continued to have a high level of dull, throbbing, burning and constant pain. She had not had her blood pressure checked and reported that the pain wakes her up 3 to 4 times per week. Claimant reported that her shoulder is always aching and radiates down into the tips of her fingers. Claimant was instructed to continue with physical therapy and

was allowed to work modified duty with restriction of no lifting over 10 pounds and no overhead work.

Claimant was last seen by Dr. Prohaska on December 22, 2011. She exhibited a 15 percent improvement, but continued to have a high level of pain. She also reported the pain had jumped to her left arm and she ached every day. Dr. Prohaska felt that claimant had reached a plateau as far as recovery and recommended an FCE to determine what restrictions would be appropriate, before placing her at maximum medical improvement. He did not feel that she would benefit from any further treatment. Claimant's FCE was reviewed and Dr. Prohaska determined claimant could return to work with permanent restrictions including no overhead work. He did not provide an impairment rating, but offered to do so upon request.

Dr. Prohaska did not feel that claimant had any injury or need for any impairment rating to the left upper extremity. As for claimant's neck, he opined that all of her complaints that would be related to the neck were easily explained from the shoulder exam. He did not feel that claimant had any neck impairment.

On February 13, 2012, Dr. Prohaska provided an impairment rating of 6 percent to the right upper extremity. He utilized the 4th edition of the AMA *Guides*[2] and his rating was based on range of motion.

At the request of her attorney, claimant met with board certified independent medical examiner, Daniel D. Zimmerman, M.D., on February 28, 2012. Claimant appeared with chief complaints of pain and discomfort affecting both shoulders and the cervical spine. Claimant reported that she continued to have burning pain affecting the right shoulder and pillar pain affecting the right hand and loss of grip on objects she is holding in her right hand. Claimant reported pain affecting the left shoulder and palmar pain with tingling affecting the second through the fifth digits of the left hand.

Dr. Zimmerman opined that the prevailing factor for claimant's paraspinous myofasciits, right shoulder rotator cuff tear; SLAP type 1 tear; and impingement syndrome was her repetitive work duties for respondent. He went on to assign a 24 percent whole body permanent partial impairment (5% permanent partial impairment to the body as a whole for chronic cervical paraspinous myofascitis; 19% to the right upper extremity at the right shoulder for permanent residuals of the surgery to repair the rotator suff and management of a SLAP type I lesion (11% whole body); 17% to the left shoulder for impingement syndrome of osteoarthritis affecting the acromioclavicular joint (10% whole body).

[2] American Medical Ass'n, *Guides to the Evaluation of Permanent Impairment* (4th ed.).

Dr. Zimmerman assigned the following restrictions: avoid lifting more than 20 pounds occasionally, 10 pounds frequently; avoid hyperflexion and hyperextension of the cervical spine, or holding the cervical spine in captive positions for extended periods of time; avoid work activity at shoulder height or above on the right and left sides; and avoid frequent flexion, extension, twisting, torquing, pushing, pulling, hammering, handling, holding and reaching activities using the right and left upper extremities.

Dr. Zimmerman reviewed the list of tasks from vocational expert Jerry Hardin, and opined that claimant could no longer perform 11 out of the 12 tasks on list, for a 92 percent task loss.

Claimant met with Jerry Hardin on April 12, 2012, for a vocational assessment. Claimant's daughter served as an interpreter for claimant who does not speak English. Mr. Hardin found claimant to have a 100 percent wage loss and a 93 percent task loss for 96.5 percent work disability. He also opined that although claimant cannot read or write, she can speak and understand English a limited amount and, taking into consideration her physical health, education, training and tasks performed over her past work history before the injury, there was comparable substantial, gainful employment she had the ability to perform.

At the order of the ALJ, claimant was referred for an IME to board certified physical medicine and rehabilitation specialist, Vito J. Carabetta, M.D., on August 7, 2012. During the examination, claimant's cervical spine was found to be asymptomatic, with a full range of motion, with only trace discomfort towards the right shoulder. Upper extremity range of motion testing was normal, except for the right shoulder. Claimant was diagnosed with post right shoulder rotator cuff repair and subjective neck pain. Pursuant to the AMA *Guides*, Dr. Carabetta rated claimant at 10 percent impairment to the right upper extremity at the level of the shoulder. However, due to the severity of the right shoulder injuries, and the adhesive capsulitis complications, Dr. Carabetta suggested an 18 percent functional impairment of the right upper extremity at the level of the shoulder would be more in line with the *Guides*. He gave no impairment rating for claimant's subjective cervical complaints, finding her neck to be unratable under the *Guides*. He also found no ratable impairment with regard to claimant's left shoulder.

PRINCIPLES OF LAW AND ANALYSIS

In workers compensation litigation, it is the claimant's burden to prove his or her entitlement to benefits by a preponderance of the credible evidence.[3]

[3] K.S.A. 2010 Supp. 44-501 and K.S.A. 2010 Supp. 44-508(g).

The burden of proof means the burden of a party to persuade the trier of fact by a preponderance of the credible evidence that such party's position on an issue is more probably true than not true on the basis of the whole record.[4]

K.S.A. 2010 Supp. 44-501(a) states:

> (a) If in any employment to which the workers compensation act applies, personal injury by accident arising out of and in the course of employment is caused to an employee, the employer shall be liable to pay compensation to the employee in accordance with the provisions of the workers compensation act. In proceedings under the workers compensation act, the burden of proof shall be on the claimant to establish the claimant's right to an award of compensation and to prove the various conditions on which the claimant's right depends. In determining whether the claimant has satisfied this burden of proof, the trier of fact shall consider the whole record.

K.S.A. 2010 Supp. 44-510e(a) states in part:

> Functional impairment means the extent, expressed as a percentage, of the loss of a portion of the total physiological capabilities of the human body as established by competent medical evidence and based on the fourth edition of the American Medical Association Guides to the Evaluation of Permanent Impairment, if the impairment is contained therein.[5]

Claimant contends she suffered permanent injuries to her right shoulder, left shoulder and cervical spine, based on the opinion of Dr. Zimmerman. She also contends she is entitled to an award of a permanent partial general disability based upon Dr. Zimmerman's task loss opinion and the fact claimant has only worked a part of one day since her date of accident on October 21, 2010. Respondent contends claimant's award should be limited to a functional impairment to the right upper extremity at the level of the shoulder and argues the most credible opinion is Dr. Prohaska's 6 percent upper extremity functional impairment rating.

The ALJ found the independent medical opinion of Dr. Carabetta to be the most persuasive, and the Board agrees. Claimant has failed to prove permanent impairment to either her left shoulder or her neck as the result of her injuries suffered while she worked for respondent. The only doctor finding claimant to have suffered more than a right shoulder permanent impairment is that of Dr. Zimmerman. The Board finds his multiple ratings to be unsupported by the vast majority of the medical evidence in this record. The Award of the ALJ is affirmed in all respects.

---

[4] *In re Estate of Robinson*, 236 Kan. 431, 690 P.2d 1383 (1984).

[5] K.S.A. 44-510e(a).

CONCLUSIONS

Having reviewed the entire evidentiary file contained herein, the Board finds the Award of the ALJ should be affirmed in all respects. Claimant has not carried her burden of proving a permanent impairment to either her left shoulder or cervical spine. Her permanent partial functional impairment is limited to her right shoulder. The Board finds the 18 percent right upper extremity functional impairment opinion of Dr. Carabetta to be the most persuasive and adopts same for the purposes of this Award.

AWARD

WHEREFORE, it is the finding, decision and order of the Board that the Award of Administrative Law Judge John D. Clark dated January 18, 2013, is affirmed.

IT IS SO ORDERED.

Dated this _____ day of June, 2013.

_____
BOARD MEMBER

_____
BOARD MEMBER

_____
BOARD MEMBER

c: Randy S. Stalcup, Attorney for Claimant
stalcuplaw@hotmail.com

Dallas L. Rakestraw, Attorney for Respondent and its Insurance Carrier
drakestraw@mtsqh.com

John D. Clark, Administrative Law Judge